



Središnja medicinska knjižnica

Augustin G., Kekez T., Bogdanić B. (2010) *Abdominal papular zosteriform cutaneous metastases from endometrial adenocarcinoma.* International Journal of Gynecology and Obstetrics, [Epub ahead of print]. ISSN 0020-7292

<http://www.elsevier.com/locate/issn/00207292>

<http://www.sciencedirect.com/science/journal/00207292>

<http://dx.doi.org/10.1016/j.ijgo.2010.03.004>

<http://medlib.mef.hr/751>

University of Zagreb Medical School Repository

<http://medlib.mef.hr/>

Title: **Bilateral abdominal papular zosteriform cutaneous metastases from an endometrial adenocarcinoma**

Goran Augustin, Tihomir Kekez, Branko Bogdanic

Department of Surgery, Clinical Hospital Center Zagreb

Kispaticeva 12

100000 Zagreb

Goran Augustin, MD, MSc (corresponding author)

E-mail: augustin.goran@gmail.com

KEYWORDS: Zosteriform skin metastases; Endometrial carcinoma

Synopsis: Cutaneous metastases from endometrial cancer are very rare with several morphologic types. Extremely rare is the morphologic variant of abdominal zosteriform cutaneous metastases of various primary tumors with this second known case.

Word count: 464

Conflicts of interest: none declared.

We report an extremely rare case of bilateral abdominal papular zosteriform cutaneous metastases from an endometrial adenocarcinoma.

A 78-year old woman underwent hysterectomy and bilateral adnexectomy via lower midline laparotomy for endometrial adenocarcinoma stage FIGO IIIC with postoperative systemic polychemotherapy, radiotherapy (50 Gy) and transvaginal brachytherapy (25Gy). After 2 years, multiple red, indurated, papules developed in dermatomal zosteriform distribution of anterior abdominal wall at level of T10-12 bilaterally; the most abundant changes are near the laparotomy scar. These were identified when the patient presented to the Emergency Room with mechanical bowel obstruction and ascites (Fig. 1). Excisional biopsy showed circular islands of atypical glandular epithelial cells infiltrating the superficial and deep dermis, consistent with metastatic adenocarcinoma.

The incidence of cutaneous metastases increased from 2.7% in 1969 to 10% nowadays, due in part to a growing awareness of this condition, in part to a rise in cancer rates, and in part to longer survival times granting skin metastases an opportunity to develop [1]. There are several morphologic types including macules, papules, nodules, indurated plaques, purpuric plaques mimicking vasculitis, discoid lesions and tumor nodes with teleangiectasia.

Cutaneous metastases of the abdominal wall are extremely rare. There are two forms. One is after surgery, called *incisional* (6 cases published), *port-site (trocar-site)* or *drain-site* metastases due to inoculation and direct spread of the tumor with better survival measured in years after complete excision. The other form is due to natural history of the disease which indicates an end-stage disease with survival measured in months. Often the regions of cutaneous metastases concur with the field of previous radiation therapy which obliterates small lymphatic channels thus facilitate the implantation of tumor cells. The incidence of skin metastases in endometrial carcinoma is unknown but in the cervical cancer is 1.3% with an

increasing order from 0.8% in stage I to 4.8% in stage IV. The abdominal wall and vulva are the most common skin sites, followed by the anterior chest wall [2].

Cutaneous metastases in endometrial cancer could be solitary or multiple. Sister Mary Joseph's nodule (umbilical metastasis - less than 30 cases published) is due to direct extension of primary tumor. Zosteriform cutaneous metastases of any primary tumor are extremely rare with only 56 cases described. [3]. The histotypes of primary tumors are as follows: melanoma (18%); lymphoma (14%); breast cancer (12%); squamous cell carcinoma (12%); and digestive - stomach and colon (10.7%), pulmonary (8.9%), and urinary tumors (7%), and others (17%). In only one case a typical herpetiform pattern was described, whereas in the others the papulonodular lesions with a dermatomeric distribution were present. This meta-analysis did not include the first case report recently published of zosteriform metastases of endometrial cancer [4] and this is the second known case but the first case with bilateral papular zosteriform abdominal metastases.

Conflicts of interest: none declared.

References

- [1] Poole S, Fenske NA. Cutaneous markers of internal malignancy. I. Malignant involvement of the skin and the genodermatoses. *J Am Acad Dermatol* 1993;28(1):1–13.
- [2] Imachi M, Tsukamoto N, Kinoshita S, Nakano H. Skin metastasis from carcinoma of the uterine cervix. *Gynecol Oncol* 1993;48(3):349–54.
- [3] Savoia P, Fava P, Deboli T, Quaglino P, Bernengo MG. Zosteriform cutaneous metastases: a literature meta-analysis and a clinical report of three melanoma cases. *Dermatol Surg.* 2009;35(9):1355-63.

[4] Werchau S, Hartschuh W, Hartmann M. Zosteriform metastasis of endometrial cancer.
Eur J Dermatol 2009;19(4):401-2.

Figures

Figure 1 Multiple red, indurated, papules in dermatomal zosteriform distribution of anterior abdominal wall at level of T10-12 bilaterally.

